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## **Disordered Eating and the Contradictions of Neo-liberal Governance**

Scholars from a range of academic fields and theoretical perspectives have drawn attention to the contradictory demands that neo-liberal public health regimes and systems of food provisioning place on individuals (LeBesco, 2011; Guthman and DuPais, 2006; Puhl and Heuer, 2010). On the one hand, the public health regime demands that individual subjects/citizens take responsibility for the management of their own bodies. On the other hand, contemporary de-regulated food systems are seen to promote forms of consumption incompatible with the demands of 'responsible' self-management.<sup>1</sup> A focus on the contradictions that capitalism generates is most readily associated with Marx (1992). Marx, however, was principally concerned with the development of contradictions at the level of the system as a whole. For example, the tension between the need for individual capitalists to increase the rate of exploitation and the collective interest of the capitalist class in maintain wage levels that allow workers to play a proper role as consumers. Scholars interested in the contradictions between neo-liberal systems of corporal management and food provisioning focus primarily on the level of the individual; the distress that individuals may experience as a result of the conflicting pressures that these systems generate (LeBesco, 2011; Gutham and DuPais, 2006; Puhl and Heuer, 2010).

The paper seeks to build upon this literature by drawing attention to how changes in food systems and citizenship regime associated with the rise of neo-liberalism may have contributed to the growth of both bulimia and binge eating disorder (BED). We argue that the growth of these disorders can be related to wider temporal changes in patterns of eating and the simultaneous normalization/demonization of bingeing within contemporary food systems. The American

Psychiatric Association (2013: 350) defines a binge as “eating in a discrete period of time an amount of food that is definitely larger than most people would eat during a similar period”. Bingeing is also associated with “eating much more rapidly than normal” (ibid: 350). If we accept this definition based primarily upon the volume and rapidity of consumption then we can usefully apply the concept to an analysis of the development of contemporary food systems. Most low-cost restaurants offer standard meals that contain over 2000 calories (see below) that are often consumed in a little over 10 minutes (Rozin et al. 2003: 253). According to Young and Nestle (2002) the largest portion sizes now available in fast food outlets are between 2 and 5 times the size of the largest available in the 1950/60s (Young and Nestle, 2002). If judged exclusively in terms of volume of consumption many visits to contemporary low cost restaurants involve bingeing. While the physiology of these experiences is radically different, the size of large fast food meals and the size of binges in outpatients being treated for bulimia (1173 to 2632 calories) and BED (1515 to 2963) are similar (Cooper, 2003: 27; Mitchell et al, 2008: 36). We also argue that the increasing sale of snack and confectionary products in multipacks/share bags promotes very large acts of consumption at variance with historical norms that could also be considered as binges.

The impact of changes in food systems must be read alongside the development of a neo-liberal mode of governance that priorities individual responsibility. The utility of the concept of neo-liberalism has been questioned (Birch, 2015). Furthermore, even those scholars who employ the term are clear that the composition of neo-liberal projects will differ markedly across space and time, the neo-liberalism of the Blair administration was very different from that of President Reagan (Peck, 2001). Nevertheless, we would argue that neo-liberalism is a useful

concept for helping us understand how systems of governance have evolved in the UK since the breakdown of the post-war social democratic settlement in the 1970s.

Neo-liberalism is best defined through a shift in the locus of intervention from the macro to the individual level and the selective extension of market processes/disciplines. The social democratic project was premised on the assumption that it was appropriate for the state to actively manage markets and to decommodify key aspects of social life. In concrete terms the social democratic state committed itself to maintaining full employment through the use of fiscal and regional policies, to insuring a reasonable degree of equality through redistributive taxation and labour market regulation, to providing accommodation for low-income citizens through the expansion of public housing, and to funding the growth of higher education (Jessop, 2002). The neo-liberal state, on the other hand, cedes reasonability for guarantying key social outcomes and marketises the provision of key services. A universal guarantee of employment is replaced by a focus on improving the employability of individuals (Peck, 2001; Jessop, 2002). Public housing and pension provision are scaled back and individuals must secure these goods through market exchange. A focus upon the direct provision of public goods is replaced by an emphasis on remodelling behaviour to create 'responsible neo-liberal subjects'. Welfare support is focused on those who fully commit themselves to engagement with the labour market (Working Tax Credits), homeownership is promoted/subsidised (Help to Buy Scheme) and people are incentivised (through tax relief) and instructed to purchase private pensions. The logics of neo-liberal welfare governance have been extended to problems relating to the overconsumption of food. These problems are seen as being a

consequence of the failure of individuals to act as responsible consumers (Gutham and DuPais, 2006; LeBesco, 2011).

Clarke et al (2010) have argued that biomedicalisation represents an important component of the neo-liberal project. Biomedicalisation is seen to involve a shift from a focus on the treatment of illness to the prevention of possible illness through individualised risk profiling. Individuals face a moral imperative to act as responsible informed medical consumers who purchase the appropriate medical technologies to enhance their lives and effectively manage risk. Medical and quasi-medical technologies (activity monitors, dietary supplements etc) are embedded into the everyday lives of people who would have traditionally been defined as well. Individuals must not simply aim to achieve a 'normal' non-pathological state but rather to develop enhanced resilience through the purchase of appropriate technologies. Responsibility for health is individualised and 'wellbeing' is transformed into a commodity.

The concept of biomedicalisation is an important one that captures the manner in which key public health issues (obesity) are understood within contemporary Britain. However, it is less clear how the framework can be applied to the growth of eating disorders or the use of disability benefits to manage the social dislocations associated with neo-liberal restructuring. Here the focus is on existing illness not the risk of future illness. Furthermore, by virtue of their condition/lack of income individuals are seen as incapable of securing their own health through the responsible consumption of medical technologies and are instead seen as requiring clear direction from a clinician. Clarke et al (2010) tend to see biomedicalisation as superseding medicalisation. However, we would argue that the neo-liberal project has involved

both biomedicalisation and the further growth in more conventional processes of medicalisation.

Importantly, both medicalisation and biomedicalisation have the potential to transform the social into the biological. As such both have the potential to draw attention away from the social problems that unregulated markets create. In so doing, they reduce the pressure on the state to intervene in the market.

In order to advance these arguments the paper is divided into three sections. The first section of the paper is focused on the development of 'new' eating disorders since the late 1970s. We argue that prior to the late 1970s disordered eating was seen as a limited problem. There were no specialist academic journals focused on disordered eating and the recorded instances of eating disorders within the medical system were relatively low. The development of a new understanding of disordered eating as a widespread psychological/social problem can be dated to the 1980s. The second section focuses on the changes that have taken place in the system of food provisioning in terms of the normalization of bingeing and the partial breakdown of fixed patterns of eating. We highlight the importance of increasing income inequality, associated with the neo-liberal turn, in facilitating the development of new patterns of consumption. The final part of the paper is focused on the social construction of the obesity 'crisis'. In the absence of officially sanctioned moral condemnation of those who fail to manage their bodies 'correctly', individuals may still binge. However, the feelings of guilt associated with the act of bingeing, which are found in an extreme form among individuals diagnosed with BED and bulimia, may be less prevalent.

Given the range and scope of the issues addressed we are forced to rely upon existing empirical studies in advancing many of our central claims. The value of the

paper lies, in large part, in how it connects different bodies of scholarship (on the psychology of BED/ bulimia, the development of food systems, welfare state restructuring etc.) that have largely failed to engage with each other to generate a novel argument. Furthermore, by using government data (Annual Earning Surveys) and the fast food industry's own reports we are able to place commonly held assumptions concerning the development of wage inequality and fast food industry on a stronger evidential basis. While the dependence of the fast food industry on cheap labour is often assumed, we believe that this is the first academic paper to provide, in the context of the British fast food industry, the statistical evidence to support this assumption. The potential links between the development of new forms of consumption (buffet eating, fast food restaurants and multi-packs) and the increased prevalence of eating disorders has not previously been explored within the academic literature. In order to support our key claims we analyse discourses surrounding these new consumption practices within an online weight-loss community and how members of this forum see them as affecting their eating behaviour. While our research on the links between changes in food systems and levels of bingeing is of a limited exploratory nature it demonstrates the anxieties these forms of consumption generate among individuals who self identify as having weight issues. As such it opens up a novel and potentially important area of research for scholars interested in disordered eating.

The paper confines itself to an analysis of the evolution of systems of food provisioning and the regime of corporal citizenship in the UK. A clear focus on the UK is necessary for reasons of space and clarity. However, there are important similarities in how these systems have evolved over the last 35 years across the core capitalist world (Wight and Harwood, 2009; Gutham, 2011; Dixon et al, 2014).

Where there are deficiencies in relation to the literature on the UK we make use of case studies from other core capitalist states.

### **The Medicalization of Eating and the Development of New Forms of Disordered Eating**

The construction of female self-starvation as a medical condition (anorexia nervosa) can be dated back to the 19<sup>th</sup> century (Brumberg, 2000). The consolidation of a dominant medicalised understanding of disordered eating long pre-dates the global neo-liberal turn. However, it was not until 1980 that bulimia was included in the American Psychiatric Association's diagnostic manual (Cooper, 2003: 7). BED was only afforded the status of a distinct condition by the American Psychiatric Association in 2013. Until 1981, when the *International Journal of Eating Disorders* was established, there were no specialist psychiatric/ psychology journals focused on eating disorders. Records from the Dutch and US medical systems indicate that around 5 people in every 100,000 were diagnosed with an eating disorder annually in the 1970s (Hoek, 1995: 209; Hoek and Hoeken, 2003). Epidemiological studies, such as they were, from before the 1980s necessarily confined themselves to measuring the prevalence of anorexia (Hoek and Hoeken, 2003 387). As a result they inevitably produced vastly lower estimates of the prevalence of eating disorders than later studies (ibid). In the 1970s we saw a relatively small number of specialists focus on what was understood to be a limited problem.

Since the 1980s the study of eating disorders and the role of the medical profession within the eating regime has been transformed. 'Eating disorder studies' has since developed into a major sub-discipline within both psychiatry and



psychology that can boast a number of respected specialist journals (International Journal of Eating Disorders, European Eating Disorder Review, Eating Behaviours, Eating Disorders). GP records indicate that 37 out of every 100,000 people aged between 10 and 49 are diagnosed as suffering from an eating disorder annually (Beating Eating Disorders, 2015: 22). Furthermore, a 2004 report commissioned by the National Institute of Clinical Excellence estimated that 1.6 million people in the UK suffer from an eating disorder and would benefit from access to medical assistance (National Collaborating Centre for Mental Health, 2004).

The transformation of the ‘status’ of disordered eating from a limited problem to one of the leading psychological problems facing advanced capitalist societies is a complex and multifaceted one. We do not seek to provide a comprehensive analysis of this phenomenon. That said, we would argue that the development of formal definitions of bulimia and BED probably reflected an increase in the prevalence of these behaviours. Historians of female self-starvation have argued that there was a sharp increase in levels of self-starvation in the nineteenth century (Brumberg, 2000). Understood against this context, the medical profession did not so much create or discover ‘anorexia’ as colonise and define an emerging social problem within its area of expertise. It is equally plausible that the formal definition of bulimia in the late 1970s reflected an increased prevalence of bulimic behaviours and the extent to which clinicians were encountering patients displaying these behaviours (Russell, 1979). Before this point there was a substantial population of anorexics who binged/purged, and we do not deny the complex linkages between these conditions, but these practices seem to have been relatively uncommon in individuals of a ‘normal’ weight – bulimia can only be diagnosed if a individual does not meet the weight criteria associated with anorexia (Blinder and Chao 1994). Similarly, it seems reasonable to

assume that the formal recognition of BED as a distinct physiological disorder, at least in part, reflected an increase in the number of people for whom binge eating was a cause of distress.

The hegemony of the medical paradigm has served to depoliticise the increasing prevalence of disordered eating since the 1980s. Within the major psychiatry/psychology textbooks on eating disorders the primary focus is on establishing the commonalities that sufferers share and the effectiveness of different treatments (Brownell and Fairburn, 1995; Treasure et al, 2003; Thompson, 2004). The role of macro-level structures in the development of disordered eating is effectively relegated to secondary status. The construction of a distinct population group as 'ill' can obscure the ways in which the behaviour of 'disordered eaters' reflects, albeit in a more extreme form, more general issues surrounding food and concepts of responsible self-management. This is depoliticizing. For example, if we were to accept that there may be a link between the normalization of bingeing across society as a whole and the development of BED this would invite a challenge to the legitimacy of contemporary capitalist food systems. On the other hand, an approach that defines sufferers of BED as a special population, to be understood through a medical lens, has the potential to obscure wider social questions.

Medicalization as a governance strategy is particularly important for the neo-liberal state due to its reluctance to intervene within the market processes (Moncrieff, 2008). The most significant example of this in the UK relates to the use of incapacity benefit. In the UK the number of working age people claiming this benefit increased from approximately a million in 1980 to 2.7 million in 2003 (McVicar, 2008: 115). In areas of high deprivation over 15 per cent of the working age population are in receipt of disability benefit, as opposed to 2 per cent in most affluent areas (McVicar, 2013:

1267). In part this represents disguised unemployment. By allowing a substantial number of people in the areas most severely effected by neo-liberal restructuring to define themselves as ill rather than long-term unemployed the state masks the full impact of neo-liberal economic restructuring and alleviates pressure to engage in *dirigiste* regional policies that violate basic neo-liberal principles. The disability figures also reflect high levels of ill health in deprived areas that should be understood, at least in part, as a product of the traumas of neo-liberal economic restructuring (Bartley, 1994). The medicalisation of these issues transforms them from ones rooted in the structures of capitalism to problems of individual dysfunction.

By focusing on the relationship between changes in the wider political economy/food regime and the development of bulimia and BED we seek to politicise these disorders. A core diagnostic component of both bulimia and BED is bingeing accompanied by distress and guilt (American Psychiatric Association, 2013: 345-50). Equally significantly, sufferers from both disorders are understood to have temporally chaotic patterns of consumption. Bulimics eat relatively little outside of binges and frequently skip conventionally defined meals (Gendell et al, 1997). Individuals with BED display a similar pattern of behaviour to bulimics. Strict calorie restricted diets are broken by relatively frequent unplanned binges (Mitchell, 2008). In order to better understand the historical development of these disorders it may be productive to analyse how bingeing has been normalised within contemporary society and the wider breakdown of fixed temporal patterns of food consumption.

### **The Normalization of Binging and the Temporal Disorganization of Eating**

There exists a sizeable literature on how contemporary food systems promote

overconsumption (Young and Nestle, 2002; Cutler, 2003). However, this analysis has focused upon increases in average portion size and/or the role of snacking in explaining higher levels of consumption. There has been no systematic analysis of how very large meals, at variance with historical norms, have come to be integrated into the food regime. A study of the growing significance of these meals must begin with the low cost restaurant sector. The size of this sector, defined as including all establishments where average spend is less than £15 per head, grew in real terms from £2.4 billion in 1974 to £40.5 billion in 2008 (Allegra Strategy, 2009: 8). By 2009 one in eight meals in the UK was being eaten outside the home (ibid: 3). As has been well-publicised leading fast food chains offer meals that equal or exceed daily recommended calorie intake - for example a triple whopper burger, large fries and a large chocolate milkshake from Burger King contains 2,500 calories.<sup>2</sup> In addition to being large these meals are consumed exceptionally quickly. In America the typical McDonalds' consumer finishes their food within 13 minutes (Rozin et al. 2003: 253). Established fast food chains (McDonalds, Burger King) set norms for new entrants, including those operating at a slightly higher price point. Some of Nando's standard meal deal options together with a cheesecake for dessert contain over 2,100 calories – if the customer chooses a 'bottomless' drink this increases the overall intake.

Our research (see below) indicates that one of the most important means through which bingeing has been integrated into the contemporary food system is through all-you-can-eat buffets. There are no comprehensive statistics on the number of buffet restaurants in the UK. In order to get some sense of their importance we studied Yellow Pages listings for an English city in the West Midlands with a population of 337,000. 151 restaurants are listed within the Yellow Pages, 8 of these are specialist buffet restaurants. A telephone survey of all Indian and Chinese

restaurants listed revealed that 14 of 36 Indian restaurants and all but one of the 33 Chinese restaurants offer a buffet at some point in the week.

It is not only through the restaurant sector that very large acts of consumption have been normalised. We would argue that the increasing extent to which confectionary and snack products are been sold in multipacks or share size bags has also contributed to the normalization of such acts. In the confectionary sector, for example, share bags now account for 44 per cent of sales by value and 60 per cent by volume in the UK (Scottish Grocer, 2013). Vermeer et al (2010) conducted a study on how individuals who purchased a two pack of king sized chocolate bars planned to consume them. 93 per cent intended to eat both themselves within the next 24 hours. The total size of the bars was relatively modest (668 calories) and if we were to study larger multipacks we would expect this figure to fall. However, it seems unreasonable to expect the figure to fall to negligible levels until we reached very large food items.

The physical properties of processed food and foods served within the low cost restaurant sector make it difficult for eaters to manage their levels of consumption. Foods high in sugar (or artificial sweeteners), fats, refined carbohydrates and salt have been defined as ‘hyper-palatable’ (Fortuna, 2012). The neurological effects of these foods are seen as fundamentally different from more traditional foods. These effects have been compared to those generated by the consumption of recreational drugs (Ifland et al, 2008). As has been well documented the levels of fat, sugar and salt within processed foods is very high and the use of these ingredients has been integral to the growth of the processed food industry (Moss, 2013). Many processed foods, such as ready meals that are cooked and then frozen, would be tasteless without the use of these ingredients. Major food manufacturers maintain sizeable research departments devoted to determining the

exact balance of fats, sugar, salt and additives that maximise the palatability of their foods (ibid). The use of fat, sugar and salt to increase palatability is not, of course, a new phenomenon. However, the use of scientific method to determine the optimal combination of these ingredients and their use in conjunction with other synthetic additives is more novel and potentially troubling (ibid).

It would require a large-scale research project to establish the extent to which the changes in the food regime outlined above has led to increases in the level of bingeing among the general population. However, by analysing online weight management forums we can get a sense of how individuals who self-identify as having tendencies to binge see these changes as effecting them. The forum “3 fat chicks on a diet” (<http://www.3fatchicks.com/forum/>) was established in 2001 and has just over 200,000 members, who are overwhelmingly female. We selected this forum because of its size and the wide range of issues it covers - as opposed to the Weight Watchers forum that is more narrowly focused on discussions of the diets this firm prescribes. Women from a variety of English-speaking countries participate in this forum. The website is organised into a number of sub-forums (weight loss and depression, men’s corner, medical issues and dieting etc.). The sub-forum that we are interested in focuses on overeating and bingeing. As of June 2015, the forum contained 4754 different threads. In its first few years of operation, when it was far less active, the forum included posts by individuals who self-identified as bulimic. However, the forum has come to be dominated by people who do not purge. We read the 1000 most recently active threads to get a sense of what was discussed within the forum. Within these threads posters focused upon why they binge, the experience of bingeing and the strategies they employ to control their tendencies to binge. Only 5 of these threads included a discussion of being diagnosed with, or receiving medical treatment for, a

eating disorder– although discussions of this nature appear more common in early threads. We used the website’s own search tool to isolate those threads within the sub-forum that referred to buffets (169) or one or more of the five largest fast food chains in either the UK or US (411) by name – 13 threads referred to both fast-food chains and buffets.<sup>3</sup> While a small minority of posters celebrated their restraint when visiting a buffet or fast food restaurant the majority of posters saw these restaurants as sources of difficulty and anxiety. Fast food was invariably consumed as a take-away (normally purchased via a drive through) and the eater frequently ordered additional drinks to give the server the impression that food was intended for group consumption. Posters referring to buffets typically reported being unable to avoid these. Friends, partners and family would arrange meals at these venues or buffets would be served at work-related conventions and/or away days.

References to both fast food and buffets were far more common in threads in which the poster detailed a particular binge that broke a period of successful self-restraint. 56 of the 1000 most recently active general threads were concerned with a single binge event rather than a more general discussion of bingeing. However over 25 per cent of total threads dealing with buffets (47) and 20 per cent of fast food (87) related threads were focused on a single binge. Visits to buffets were unique in the role they played in restarting bingeing behaviour. In the case of other reported binges, involving the consumption of fast or shop bought food, there was almost always a trigger external to the food system (work, relationship issues). The eater was normally distressed prior to bingeing. In the case of buffets, however, posters frequently reported being in a general positive or at least neutral mood in the period before a buffet visit, necessitated by work or family commitments, restarted a cycle of guilt related consumption.

Perhaps unsurprisingly, the majority of self-defined binges (23 out of a sample of 33) that did not involve fast food and took place in the home environment included the consumption of foods marketed as containing multi-servings (share bags/multipacks) in a single sitting. This does not mean that no binge would have taken place in their absence. However, several posters suggested that share bags encouraged bingeing. Indeed, many posters made it clear that they only buy certain items (ice cream, chocolate) in single individual sized servings for this very reason. Ironically posters frequently reported bingeing on diet foods that had been purchased in multipacks – for example Weight Watchers snack bars.

Obviously, our analysis of the impact of changes in the food system on individuals with a (self-defined) tendency to binge is of a limited exploratory nature. We do not wish to make an unsustainable set of claims on the basis of a limited informal study. At the same time, however, it demonstrates the plausibility of a link between the development of the low-cost restaurant sector, the sale of products in share size packs and increases in binge eating. More vigorous, comprehensive research is necessary to establish the strength of this link.

An analysis of how wider changes in the food systems may have contributed to increases in disordered eating should also consider changes in temporal rhythms of consumption. A survey of 826 adults in Nottingham in 2001 revealed that 29 per cent regularly, at least once a week, missed breakfast and a further 23 per cent regularly missed lunch (Pettinger et al, 2006). To place these findings in context, meal structures appear to have been rigidly adhered to the 1960s (Siega-Riz et al, 1998).<sup>4</sup> Eating patterns have become more chaotic as individuals increasingly miss meals and engage in unstructured grazing/snacking.



It is important not to overstate the similarities between the generalised breakdown in fixed temporal patterns of eating and the forms of temporally disordered consumption associated with both BED and bulimia. Most individuals continue to follow at least a semi-structured pattern of eating. However, we would argue that it is productive to explore the linkages between the low-level generalised de-structuring of eating patterns and the increasing prevalence of binge-based eating disorders where we see a more fundamental breakdown in eating patterns.

The development of the forms of eating outlined above cannot be understood outside of the collapse of the post-war growth regime, rising inequality and the increasing influence of neo-liberal economics. The argument here is less about the agricultural sector itself than the fast and processed food industries. Obviously, these eating practices require that certain key ingredients, particularly meat, are relatively cheap. According to the Economist Food price index, however, the two historic lows of world food prices were in early 1960s and the turn of the millennium (cited in Baines, 2013). Cheap food clearly predates the development of many of the eating practices outlined above and the wider turn towards neo-liberalism.

The growth of income inequality, which cannot be divorced from the broader neo-liberal project, has played a far more direct role in shaping the development of the fast food industry. Since the mid 1970s wage inequality in the UK has risen sharply. Between 1977 and 2002 wages for the highest earning 10 per cent of workers increased by 97 per cent whereas wages for the bottom 10 per cent increased by 27 per cent (National Equality Panel, 2010: 28). In the mid 1970s the low cost restaurant sector was approximately 5 per cent of its current size (Allegra Strategy, 2009: 8). The rise in wage inequality has been integral to the growth of the sector. The average (median) weekly wage in the food and beverage service industries in 2014 was £181

as opposed to an economy wide average of £418 (Office of National Statistics, 2014). Wages in this industry are the second lowest, after cleaning, of any major industry in the UK (ibid). In 2010 gross value added per employee in food services was only £14,300, compared to an economy wide average of £34,090 (People 1st, 2013: 17). The viability of the dominant business model within the restaurant sector rests upon the existence of a pool of low-wage flexible labour. As such the development of the industry cannot be understood outside of labour market deregulation, welfare state restructuring, deindustrialization and the decline of trade unionism (Harvey, 1990). In other words, the development of the low-cost restaurant sector cannot be separated from the broader neo-liberal project.

Neo-liberal labour market reform has played an important role not simply in ensuring a supply of cheap labour for the fast food industry but in creating additional demand for the products of this industry. While the widespread use of shift work can be dated to the origins of industrial capitalism, the neo-liberal turn has led to increasing number of workers being employed on highly flexible terms with erratic variable hours of work - zero hour contracts would be the most extreme version of these arrangements (Work Foundation, 2013). Dixon et al (2014) demonstrate how these workers find it impossible to follow traditional meal patterns. These workers frequently eat on 'the run' and rely more heavily than the general population on convenience food, takeaway and cheap restaurants to meet their nutritional needs. Furthermore, the concepts of supersizing and share bags that offer large increases in the quantity of food relative to price may have greater appeal to low-wage workers, who feel a greater need (consciously or otherwise) to pursue value, than more affluent consumers. .

Changes in the broader political/economic climate have played a critical role not simply in the development of new forms of food provisioning but in the construction of a dominant understanding of obesity rooted in the inability of the obese to act as responsible neo-liberal subjects. As we made clear in the introduction, our argument is that the growth of BED and bulimia are not simply products of the growth of generalised bingeing but rather the contradictions between this growth and neo-liberal norms of corporal governance.

It is to the governance of the obese, and the political uses that a focus on obesity serves, within contemporary neo-liberalism we now turn.

### **Neo-liberalism, Biomedicalisation and the War on Obesity**

The management of the population's diet has long been a central concern of the state and medical establishment. Until the mid 20<sup>th</sup> century official concern was focused on the irrationalities and inadequacies of workers' diets (Csergo, 2009). A concern with under (or incorrect) consumption among the working class was frequently combined with a secondary interest in the adverse effects of overconsumption among the relatively wealthy (ibid). What is striking about the evolution of official discourses on weight in the core capitalist area is the speed with which concern shifted from under to overconsumption in the post-war era. In Europe public health campaigns warning of the dire consequences of obesity can be dated back to the very moment systems of rationing were abolished (Oddy et al, 2009).

Throughout most of the post-war period the way in which the 'problem' of obesity was constructed was fundamentally different from today. Overeating was constructed as a problem that may lead certain individuals to suffer from poor health and die prematurely. From the 1980s onwards, however, obesity increasingly came to

be understood as *the* overwhelming public health issue that confronts advanced capitalist societies. The obese do not simply endanger their own health. Rather, the obese are seen as constituting an existential threat to the body politic itself. In his 2011 speech on healthcare David Cameron (2011) stressed that obesity must be tackled if the NHS is to be sustainable ‘Take obesity: it already costs our NHS a staggering £4 billion a year. But within four years, that figure's expected to rise to £6.3 billion’. Government reports on obesity frequently open with a statement on its ‘serious impact on economic development’ (Department of Health, 2011: 5). The costs of obesity are seen as posing a critical threat to the competitiveness of the national economy and the viability of systems of health care.

The official discourse on obesity relies upon a particular reading of the health consequences of being large - that there is a relatively simple powerful link between weight and health. Critical obesity scholars stress the extreme degree of uncertainty that exists regarding the relationship between the numerous genetic, social and lifestyle variables that determine health (Gard, 2011; Guthman, 2011). The stigmatization of the obese and the funding of research by the manufacturers of anti-obesity drugs are seen to have influenced scientific work on the relationship between weight and health (Guthman, 2011). Correlations have been presented as causal links and potential risks/links as clearly established certainties.

A belief that obesity constitutes the major public health crisis facing the UK is compatible with a range of views on how the crisis should be understood. Albritton (2009), for example, seeks to locate the problem of obesity within a Marxist critique of the illogics of the global food system. The dominant understanding of obesity presented by the media and policymakers in the UK is, however, clearly focused on perceived individual pathologies. Ultimately, individuals are obese because they fail

to act as responsible disciplined consumers. According to the Department of Health (2011: 22) 'each of us is ultimately responsible for our health.... the solution lies in each of us taking responsibility for our health and taking appropriate action to manage our weight'. The 46-page report cited above refers to individuals on 46 occasions and the food/beverage industry 14 times. The primary focus of the report is clear. The UK government's 2013 obesity policy document is framed around the concept of 'helping individuals make healthier choices' (Department of Health, 2013). We may live in an environment that promotes obesity but the virtuous citizen exercises self-control. Policy interventions, therefore, ought to be primarily focused on educating individuals in order to alter behaviour. Given this focus on individual behaviour and the fact that obesity is a risk factor rather than an actual disease the concept of biomedicalisation can usefully be applied to the UK government's anti-obesity policy. Furthermore, the growth of the anti-obesity industry is one of the primary mechanisms through which regular consumption of quasi-medical products (supplements, activity monitors etc) marketed directly to consumers is being normalised.

The focus on remodelling individual behaviour can be understood as fitting a wider neo-liberal welfare paradigm. Jayasuriya (2006) argues persuasively that liberal norms of autonomy and freedom are effectively suspended for welfare recipients whose status as deviant subjects, who are not engaged in market exchange, legitimises a highly illiberal set of interventions. The failure of particular individuals to successfully engage in market exchange is seen as a product of an inadequate work ethic, a lack of skills or an insignificantly developed sense of personal entrepreneurship. In contrast to Keynesian and Marxist approaches to understanding unemployment, which see it as a systematic problem, neo-liberalism identifies the

problem as one of personal inadequacies that the state must seek to remedy (Peck, 2001).

The obesity crisis, whether real or imagined, is a potentially attractive one to neo-liberal policymakers. By constructing obesity as the principal public health crisis facing advanced capitalist societies we draw attention away from the effects of structural economic changes in increasing health inequalities and other public health issues (e.g. industrial pollution) that are less amenable to an analysis focused on individual agency.

The particular conception of individual agency/consumer sovereignty underpinning the government's obesity policy is a very peculiar one. There is an obvious tension between continued supply side interventions (in the agricultural sector itself) and the assumption that when managing consumption 'reasonability must lie with the individual' (Department of Health 1990 cited in Fine, 1998: 60).

There is a secondary tension between the privileging of consumer sovereignty/ individual responsibility and the legitimization of official intervention to furnish the individual with the knowledge to act 'responsibly'. If state intervention is seen as being required as a result of the tendency of unregulated food markets to leave consumers ignorant this could underpin a critique of market-based food systems and undermine an individualised reading of obesity. Third, the medicalization of certain forms of obesity, associated with BED, implies that not all individuals can be held fully reasonable for their eating choices – they are recognised as ill rather than simply feckless. Finally, the focus on altering consumer behaviour ultimately assumes that consumers must be educated to conform to a particular set of behaviours or be stigmatised as irresponsible agents who threaten the competitiveness of the nation, whose appropriateness to raise children must be questioned and who represent

legitimate objects of entertainment/ridicule within the popular media. Ultimately, consumers are not seen as facing a number of legitimate choices within the marketplace but the choice between a virtuous and a deviant path. The privileging of individual choice, therefore, simply legitimates the marginalization of the obese as they can be seen to have brought any negative consequences upon themselves.

The most direct mechanism through which government intervenes to remodel individual behaviour and promote 'responsible' consumption is through the management of children's bodies. Every child in the British school system must be weighed in years 1 and 6. Parents are given these results alongside 'appropriate' advice on how to manage their children's weight (Rich et al, 2011a). Parents who allow their children to become obese or are obese themselves (and thus not providing a proper role model) are seen as failing. The possibility of removing obese children from parents has been openly suggested (Rich et al, 2011b).

The direct impact of public health campaigns on childless adults may be limited. The level of spending on these campaigns is fairly insignificant compared to private advertising budgets (Fine, 1998). The importance of these campaigns is how they serve to legitimate a wider media interest in obesity. Consumer trust in public health advice is considerably greater than the claims of private firms (ibid). Public health discourses surrounding obesity and notions of the 'good' diet play a critical role in allowing health/diet foods to market their products as virtuous. More significantly still, official pronouncements regarding the obesity crisis have created a space for the development of a weight based entertainment media. The UK's five main television channels featured an average of 13 hours of weight-based peak time (6PM and 11PM) programmes per week between the 5<sup>th</sup> of August 2013 and the 1<sup>st</sup> of September 2013. The vast majority of these programmes consisted of intervention

based entertainment shows in which experts encourage the overweight to 'improve' their bodies. Sullivan and Sender (2008) argue, on the basis of audience research, that these shows contribute significantly to the stigmatization of the obese. Viewers of these shows come to see a obese body as "evidence of an inner malaise", a failure of will (ibid: 573). A similar focus on obesity and bodily management can be found in print media- for example women's magazines, men's lifestyle magazines, tabloid newspapers and celebrity magazines (Bordo, 2003).

Public health discourses render these forms of entertainment not only legitimate but even allow them to present themselves as public-spirited. These forums reproduce the same basic message as public health discourses but in a more brutal language. Both public health and entertainment forums promote a very clear message that the obese are, as their bodies testify, incapable of responsible self-management. Interventions are, therefore, not seen as compromising autonomy but teaching the obese how to manage autonomy in an appropriate manner; we intervene to create responsible free individuals. Individual freedom is, therefore, limited to freedom to act 'correctly'.

The co-existence of food systems that promotes bingeing/overconsumption and the demands of a health citizenship regime that 'requires' individuals to manage their consumption in a manner incommensurate with these practices (bingeing) generate serious tensions within individuals. The relationship between this generalised tension and the more acute set of traumas associated with bulimia/BED is a potentially highly significant one that merits further study.

## **Conclusion**



The central argument of this paper is that the growing prevalence of disordered eating can be related to particular features of contemporary neo-liberal political economy in general and neo-liberal food systems in particular. Neo-liberalism effectively creates an environment in which bingeing is simultaneously encouraged and deemed irresponsible. The neo-liberal public health regime demands that each of us take responsibility for our own health and manage our consumption in a prudent manner. On the other hand, primarily through the growth of the low cost restaurant sector, exceptionally large meals, of over 2,000 calories, have come to be integrated into everyday eating practices. The contradictory pressures that the food and public health systems place on individuals have the potential to generate considerable distress among vulnerable individuals and contribute to the growth of disordered eating.

Further research is necessary to determine the strength and exact nature of the relationship between changes in the wider political economy and levels of disordered eating. As such rather than offer a definitive set of conclusions, the paper proposes a new research agenda. Analysis of disordered eating should, we would argue, be located within a wider engagement with critical political economy. Equally, critical political economy should more consistently foreground the importance of corporal citizenship and medicalization within the neo-liberal project. There are well-developed critical literatures on the management of the obese and welfare recipients in contemporary capitalism (Peck, 2001; Jayasuriya, 2006; Wright and Harwood, 2009; Rich et al, 2011). However, these literatures frequently appear to be ignorant of each other. Moreover, there is limited interaction between scholars focused on the political economy of food and the psychology of disordered eating (Treasure et al, 2003; Mitchel et al 2008; Albritton, 2009; Oddly, 2009). We hope that this article

will act as a catalyst for greater dialogue between sociologists of (ill)health and critical political economists.

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<sup>1</sup> A food system consists of the economic, political and social structures/interactions that determine how food is produced, distributed, marketed and consumed. There exists multiple overlapping food systems organized on different spatial scales. The importance of MNCs in the agriculture, food retail and the restaurant sectors allows us to meaningfully discuss the existence of a 'global food system'. However the existence of regional/national regulation (e.g. common agricultural policy) together with structural differences in the organization of agriculture, retail systems and restaurant sectors across different political economies means we must also discuss regional, national and local food systems. Furthermore, the increasing significance of 'alterative' (organic/fair-trade/slow-food) systems of provision means that we must recognize the existence of multiple systems organized on the same spatial scale (Atkins and Bowler, 2000).

<sup>2</sup> Information on meal sizes is taken from relevant corporate websites (<http://www.burgerking.co.uk/menu>) (<http://www.nandos.co.uk/restaurantmenu/>).

<sup>3</sup> The five largest chains in the US are McDonalds, Subway, Burger King, Wendy's and Taco Bell. In the UK the five largest chains are Subway, McDonalds, Greggs, Kentucky Fried Chicken and Pizza Hut (Mintel, 2015).

<sup>4</sup> Siega-Riz et al (1998) research is focused on the US. However, there is no obvious reason why meal patterns should have been less stable in the UK than the US during this period.

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